Gotcha! Using Patient Safety Event Reports to Report People Rather Than Problems

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During a recent conference, one of us (J.S.M.) delved into murky waters by asking, "Is our patient safety event reporting system working as intended?" A resident then recounted her recent experience. The transplant surgeons evaluated one of her hospitalized liver transplant patients and informed the patient that antirejection medications were indicated. Subsequently, the patient had questions that his nurse could not answer. The nurse sent a text message to the intern to speak to the patient at the bedside. The intern, still rounding, did not know the answer to the question so texted back, "I don't know." The patient became frustrated about the lack of response, so his nurse sent several more text messages to the intern for a different response. Meanwhile, unbeknown to the nurse, the intern was simultaneously trying to contact the surgeons to obtain information, but the team was in the operating room and did not answer. By midafternoon the nurse, increasingly frustrated, phoned the intern and harshly stated, "You really need to figure this out *now*!" The intern, upset, asked her senior resident what to do. The senior resident stated that this nurse's behavior was unprofessional and filed a safety event report about her. The nurse also filed a safety event report about the intern's lack of responsiveness to a patient's needs. As the resident finishes her account, other residents are nodding their heads and many hands are raised wanting to share similar experiences.

Safety event reporting is a regulatory requirement for health care organizations and now an expectation for graduate medical education (GME) trainees.[1–3] Most hospitals employ an electronic safety event reporting system to capture these events, and increasingly, GME programs train residents on how and when to use the system. The above vignette highlights that many perceived instances of unprofessional behavior between members of the health care team fall along a spectrum and may be more accurately categorized as incivility, microaggressions, or—as in this case—miscommunication.[4,5] The scenario also illustrates how safety event reporting can insidiously produce a culture of blame, as opposed to a culture of safety. In this Perspective, we describe what we believe is a growing problem in GME: the unintended consequences of using safety event reporting systems to report professionalism concerns.

Reporting behavioral concerns in safety event reporting systems sends mixed messages about the purpose of safety event reporting: Is it to report systems problems or to express personal grievances? When reports involve an individual's behavior, there are unintended consequences. There is variability in how organizations triage and resolve safety event reports of unprofessional behavior. Some relay them to leaders, such as program directors and nurse managers, while others do not, leaving the reports to be managed by employees with less familiarity and responsibility for handling such concerns. Regardless of who receives the report, there are multiple vulnerabilities in the processes for resolving the concerns. Some may disregard the concern because of uncertainty around how to share the report or because of perceived lack of authority in determining next steps. If the report is viewed by someone without responsibility for the individual's overall performance, it may be seen as an isolated incident. In that situation, the organization misses the opportunity to discern whether there is a pattern of behavior that poses a more serious threat to patient safety and workplace wellness and, therefore, requires more attention. Perhaps most disturbingly, those involved in the interaction rarely have an opportunity for a psychologically safe discussion to understand each other's perspectives.

Anonymous reports related to professionalism concerns are not uncommon. In one of our institutions, 31% of professionalism safety event reports are submitted anonymously compared with 9% of all other types of safety event reports. These reports may inadvertently lead to a *worsening* of safety culture by eroding trust and respect among health care professionals and teams, which affects both patient safety and individual well-being.[6,7] Residents are less likely to speak up verbally about

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TABLE
Strategies to Optimize Professionalism and Patient Safety in the Clinical Learning Environment

Core Question	Strategy	Examples
What do we know about each other?	Develop relationships	Meet-and-greet for residents and other members of the health care team Interprofessional education session on a topic (eg, team training, new clinical pathway)
How do we communicate in times of stress or conflict?	Provide education in conflict management skills to all health care professionals	Training on how to manage conflict in the workplace
What do we do when things don't go well? Where do we share concerns about unprofessional behavior?	Design separate structures or processes for reporting and managing concerns around interpersonal behaviors vs systems problems	A mechanism for reporting professionalism concerns separate from the safety event reporting system Triage and manage behavioral concerns submitted within the safety event reporting system in a consistent relational manner

unprofessional behavior when compared with traditional patient safety threats, but they are not afraid to report anonymously in a safety event reporting system where there is more protection.[8] Power differentials, discomfort with conflict, and fear of jeopardizing relationships all contribute to avoiding direct communication related to unprofessional behaviors.[8–11] Anonymous safety event reports related to behavioral concerns are one sided and inherently biased because the organization is unable to contact the person who "reported" the other individual to gain their perspective and understand the circumstances.[12] The absence of this information can lead to defensiveness on the part of the person about whom concerns are reported and undermine a growth mindset that is foundational for continuous learning and improvement. In these scenarios, reporting builds contention rather than relationships, and the use of blame language in these reports perpetuates a punitive environment.[13,14]

Finally, reporting behavioral concerns in safety event reporting systems results in missed opportunities for teaching and role modeling relational communication. When such a report is submitted, residents and other health care team members lose a chance to develop conflict management skills.

Realizing that safety event reporting is here to stay in health care, what steps can an organization take to optimize both professionalism and patient safety in their clinical learning environment? We suggest a multipronged approach (TABLE). Institutions should create opportunities to facilitate interdisciplinary relationships outside of individual patient encounters. Activities might range from informal meet-and-greet events for staff to more formal interprofessional education on topics such as team training and the creation of a feedback culture.[15,16] These forums build relationships, stimulate understanding of other's roles and responsibilities, and help foster an environment of psychological safety for team members.[17,18]

Additionally, there should be interprofessional conflict management training. While training in conflict resolution for residents has been described,[19,20] very few programs are interprofessional.[21] The impact of these programs should be evaluated for their effect on outcomes such as safety culture or wellness.

Finally, health care organizations should reevaluate their structures and processes for managing professionalism concerns by changing how the concerns are handled and developing more productive alternatives to filing a one-way safety event report. Examples include an organization that created a safe way to discuss concerns face-to-face and a fair process for following up on such concerns.[22] Another institution captured the events within their safety event reporting system but developed a separate process that categorizes unprofessional behavior based on its frequency and provides interventions that range from an informal conversation with a coworker to disciplinary action.[23,24] Common elements in these programs include leadership commitment, institutional resources, an ability to aggregate and analyze data for trends, and a clear separation of the processes for the handling of reports relating to interpersonal problems as opposed to system problems.

Health care is hectic and complex. Miscommunications and misunderstandings abound. As the culture of reporting and learning from patient safety events continues to advance, health care leaders and educators must jointly begin an intentional effort to

manage interpersonal conflict and professionalism lapses. We support an approach that includes relationship-building opportunities, conflict management education, and structural changes for reporting with a foundation of psychological safety and relational approaches to conflict. Let's reverse the unintended consequences of conveying personal grievances in online safety event reporting systems before these maladaptive behaviors are cemented into practice.

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